

Application for Approved Provider of Sex Offender Outpatient Services

Name: _____ Date of Application _____

Agency/Clinic Affiliation (if any): _____

Agency/business owner: _____

Address of agency _____ phone number _____

is applying for (check one):

Approved Provider _____ **Approved Affiliate Provider** _____

recognition by the Utah Department of Corrections, Division of Field Operations.

1. Licensure _____

(attach photocopy of current Utah license(s))

2. Educational

Background: _____

3. **Non-licensed affiliate candidates** attach copies of transcripts to verify the above information.

4. Hours of direct clinical experience over the past three years to include a minimum of 1500 hours, with 375 hours in sex offender evaluation. (Please attach verification of clinical hours. Source documentation must be available for inspection, if requested.)

5. Formal training received in the past three years specific to sex offender treatment:

Date	Hours	Subject	Instructor(s)
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(Please attach verification of formal training. Use additional sheets as needed)

6. Please attach a complete description of your treatment program, clearly identifying the Intake, Standard and Intensive components and aftercare.

7. Please list any criminal convictions, licensing actions, ethical questions or complaints:

8. Affiliate Provider Candidates, complete sections A and B. Providers skip to number 9, Signatures.

a. Name of Approved Provider supervising work:

b. Please have your Approved Provider read and sign the following statement:

I certify that I am an Approved Provider for Outpatient Sex Offender Treatment for offenders under the supervision of the Utah Department of Corrections, Division of Field Operations, and have read and understand the criteria adopted by the Division. I further certify that I will provide a minimum of one hour of supervision for every forty hours of direct client contact the Affiliate Provider shall provide. Furthermore, I shall provide verification of this supervision to the Department upon request.

Approved Provider Signature
(For Affiliate Candidates only)

Date

9. Signatures: please sign and date your application.

Signature of Applicant

Date